Temple University Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

FY25 PROGRESS REPORT

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

TABLE OF CONTENTS

Plan to Increase Behavioral Health Access & Education 3
Plan to Expand Substance Use Disorder (SUD) Recovery Opportunities 6
Plan to Prevent & Manage Chronic Disease by Improving Access to Care 8
Plan to Address Racial, Ethnic and Other Healthcare Disparities 13
Plan to Address Social Determinants of Health (SDOH) 19
Plan to Address the Public Health Crisis of Gun Violence 25

Plan Title:
Increase Behavioral Healthcare Access and Education

Executive Sponsors:
John Robison - Executive Director, TUH-Episcopal Campus
Luciano Rasi – Director of Behavioral Health, TUH-Episcopal Campus

Health Equity Goals:

1. Increase community's behavioral health care access across other healthcare areas.
2. Strengthen patients' behavioral health services coordination following hospital treatment to the next most appropriate community healthcare provider for best outcomes.
3. Improve healthcare professional and community's knowledge of behavioral health treatment importance, options and how to access care.

Objectives:

1. Increase patients receiving behavioral health services within both behavioral health specific and non-specific medical settings (i.e. primary care).
2. Increase warm handoffs to next community behavioral healthcare provider.
3. Improve patient behavioral health appointment adherence post-hospital discharge.
4. Reduce behavioral health inpatient and Crisis Response Center (CRC) 30-day readmission rates.

Metrics Data Dashboard:

1. Number of patients receiving behavioral health services across health system.
2. Number of same day patient after care appointment "warm handoff" made to other community behavioral healthcare providers following inpatient psychiatry admission.
3. Patient behavioral health appointment adherence post-hospital discharge within 7 days.
4. Behavioral health hospital inpatient and CRC readmission rates respectively.

Data Element	Baseline	FY23	FY24	FY25
1	67,152	66,699	66,425	67,903
2	145	127	82	89
3	38.5%	44.9%	37.5%	40.2%
4	13.6%/12.2%	12.9%/10.3%	16.3%/13.3%	13.9%/11.7%

Metric Progress Summary:

1. This calculation includes CRC visits, 23-hour beds, inpatient behavioral health census days, outpatient psychiatry visits, psychiatric consults and progress notes at the patient encounter level. Integrated care behavioral health visits began in FY24 and are included in this metric. Overall volume did increase by 2% and was the highest measured during this CHNA period. In FY25 there was a significant shift from higher levels of specialized behavioral health care (crisis and inpatient services which were down 2%) towards outpatient services which were frequently provided in physical health settings (up 20%).

2. A newly implemented strategy had warm handoffs on track for a total of 208 in FY23 after the first six months. However, staffing and regulatory issues resulted in modifications to the strategy. Alternative linkage options with community partners were initiated in FY24, but none have been as successful as the initial approach. A new community service program, opened in August 2024 and located at the Episcopal campus, provided a bright start to FY25. However, this program changed their inclusion criteria around the new year and another strong community partner abruptly closed in March. These losses were partially offset by warm handoffs to the newly established Temple Substance Use (SUD) clinic.
3. This rate rose nicely in FY25, while still down from FY23 when warm handoffs were much more common. Patients waiting longer to sync with the next level of care are often less motivated and confronted by other barriers that ultimately impact the likelihood of linkage.
4. Readmission rates also decreased which correlates with the decrease in warm handoffs and 7-day follow-up, showing the importance of these linkages on both aftercare and recidivism.

Action Plans Implementation Summary:

- Work on a newly designed and relocated CRC has finished with a September 2025 target opening. Improving CRC space will allow for increased services to our community.
- Improving access to outpatient services at the Temple Psychiatry Outpatient Clinic and Temple SUD Clinic have allowed patients to receive a greater continuum of care through the health system at a time where other community resources are shrinking.
- Greater coordination between the behavioral health services at Episcopal Campus and Chestnut Hill Hospital have taken place this FY. There have been several patients moved between campuses to obtain the best level of care.
- Integrated behavioral health supports continue to be added to locations throughout the health system, providing better outcomes for patients with comorbid medical and behavioral health concerns.
- To synthesize the behavioral health services that are located throughout the health system, a Behavioral Health CMO with scope for the health system was hired in March 2025.
- There have been over a dozen educational collaborations between community programs and Temple this year. The exchange of resources and service information has proven valuable to both parties. Efforts on increasing these opportunities will remain a priority.
- Behavioral health services took part in several health fairs and mental health screenings throughout the fiscal year.

Conclusion & Next Steps:
The next CHNA is right around the corner, and will face a dramatically different health care environment than when the last one was completed. While the goals will likely remain similar, the tactics will need to evolve. A state of the art new Crisis Response Center will be critical to this mission and an eagerly awaited enhancement.

Plan Title:
Expand Substance Use Disorder Recovery Opportunities

Executive Sponsors:
John Robison, Executive Director, Temple University Hospital Episcopal Campus
Patrick Vulgamore, Director of Addiction Medicine Service Line

Health Equity Goals:

1. Increase community's access to best practice SUD treatment and other interventions to prevent drug overdose and advance recovery.
2. Improve SUD patient coordination to the most appropriate next level of care at all healthcare levels to support best outcomes.
3. Improve healthcare professionals' and community's knowledge of SUD treatment importance, options and how to access treatment.

Objectives:

1. Increase number of patient encounters made by SUD Navigation Team.
2. Increase number of successful same-day patient appointment "warm handoffs" made by SUD navigation team.
3. Increase number of healthcare professional best practice SUD treatment presentations and community events attended.

Metrics Data Dashboard:

Data is reported in averages per month.

Data Element	Baseline	FY23	FY24	FY25
Number of patient encounters by the SUD treatment navigation team.	**157.5**	**321.2**	**428.4**	**659.2**
Number of successful warm handoffs by the SUD treatment navigation team.	**28.5**	**147.2**	**192.1**	**264.7**
Number of educational outreach events Temple Health addiction professionals attend.	**0.41**	**1.17**	**3**	**6**

Metric Progress Summary:
The Substance Use Disorder (SUD) treatment navigation team at Temple Health achieved significant growth in patient engagement and outreach activities over the past fiscal years. The average number of patient encounters increased by 319% from a baseline of 157.5 to 659.2 per month. The team also saw a substantial rise in successful warm handoffs, with a 828% increase from 28.5 to 264.7 per month over the same period. Additionally, the participation in educational outreach events expanded by over 1300% from 0.41 to 6 events per month, underscoring the team's commitment to community engagement and education.

Action Plans Implementation Summary:

1. Objective 1: Increase number of patient encounters made by SUD Navigation Team.
    - A new director of SUD Engagement was hired in FY24 who has dramatically improved the operations of the team.

- This service transitioned from a grant funded program to a reimbursable service, allowing for potential expansion.
- A new comprehensive licensed outpatient SUD Clinic was established that specializes in addiction and psychiatry treatment.

2. Objective 2: Increase number of successful same-day patient appointment "warm handoffs" made by SUD navigation team.
    - THE SUD treatment navigation team has expanded options for both inpatient and outpatient referrals by:
        - Actively engaging community-based programs.
        - Regularly meeting with referral sites to understand each referral destination's requirements and key personnel.
        - Regularly meeting with community behavioral health to understand expectations placed on their network from a referral source and destination perspective.

3. Objective 3: Increase number of healthcare professional best practice SUD treatment presentations and community events attended.
    - The SUD treatment navigation team has actively pursued opportunities to exhibit at community functions and health fairs.
    - The team participates in recurring neighborhood fairs in Kensington, medical student-run clinics in North Philadelphia and attends block parties and health events as they are presented.

Conclusion & Next Steps:
By embedding best practices for SUD treatment into both physical and behavioral healthcare settings, Temple Health's treatment navigation team has dramatically expanded recovery opportunities—achieving a 319% increase in patient encounters, an 828% surge in successful same-day handoffs, and a 1,300% growth in educational outreach events. The team has delivered measurable, population-level impact across Philadelphia. Transitioning from a grant-funded initiative to a reimbursable service has been pivotal in creating a foundation for growth. The next priority is to ensure financial sustainability that secures the long-term success of this essential service, while simultaneously expanding addiction treatment options and refining patient pathways across the full continuum of care.

Plan Title:
Prevent & Manage Chronic Disease by Improving Access to Care

Executive Sponsors:
Daniel Del Portal, MD, MBA – Senior Vice President, Chief Clinical Officer, TUHS
Steven Carson, MHA, BSN, RN – President & CEO, Temple Center for Population Health
Meaghan Kim, MHA, BSN, RN – Assistant Vice President, Population Health, Temple Center for Population Health

Health Equity Goals:

1. Identify and address health outcome disparities in the community
2. Decrease percent of preventable hospitalizations among Black and Hispanic individuals
3. Provide Temple community with equitable access to proactive health screenings and disease-specific education and management to attain health and wellness.

Objectives:

1. Increase number of community members enrolled in disease management programs.
2. Increase number of patients served by Multi-Visit Patient (MVP) Clinic.
3. Decrease MVP Clinic patient acute care hospital utilization.
4. Increase rate of outpatient office visits within 7 days of hospital discharge.

Metrics Data Dashboard:

Data Element	Baseline	FY23	FY24	FY25
Number of community members enrolled in disease management programs	1612	1930	2081	2396
Number of patients served by Temple Multi-Visit Clinic	440	903	925	900
Temple Multi-Visit Clinic Patient Emergency Department (ED) utilization after Multi-Visit Clinic enrollment) *(for 90 days post-enrollment compared to the 90 days prior to first clinic visit)*	-27%	-19.4%	-57%	-58.7%
Temple Multi-Visit Clinic patient inpatient utilization after Multi-Visit Clinic enrollment *(for 90 days post-enrollment compared to the 90 days prior to first clinic visit)*	-28.4%	-48.4%	-43.8%	-57.8%
Outpatient follow-up visits within 7 days of hospital discharge	35%	79%	__	__

The updated chart data is sourced exclusively from Epic, ensuring consistency and reliability.

Metric Progress Summary:

1. Consistent Yearly Improvement in Patient Impact: The Temple Diabetes Program and Temple's Diabetes Prevention Program has shown sustained enhancement in assisting patients with diabetes.

Temple Diabetes Program:

- **FY22 Performance**:
  - 1,514 unique patients served
  - 2,784 visits completed
- **FY23 Performance**:
  - 1,792 unique patients served (18% increase from FY22)
  - 3,275 visits completed
- **FY24 Performance**:
  - 1,818 unique patients served (1% increase from FY23)
  - 3,824 visits completed
- **FY25 Performance:**
  - 1,954 unique patients served (7% increase from FY24)
  - 4,183 visits completed

Temple Diabetes Prevention Program:

- **FY22 Performance:**
  - 98 program participants
- **FY23 Performance:**
  - 138 program participants (41% increase from FY22)
- **FY24 Performance:**
  - 263 program participants (91% increase from FY23)
- **FY25 Performance:**
  - 442 program participants (68% increase from FY24)

2. The Multi-Visit Clinic continues to serve as a safety net for patients who need care for short periods of time. The updated data is sourced exclusively from Epic EMR, ensuring consistency and data integrity.

Number of patients served:

- **FY22 Performance (Pilot year):**
  - 440 patients
- **FY23 Performance:**
  - 903 patients (105% increase from FY22)
- **FY24 Performance:**
  - 925 patients (2.4% increase from FY23)
- **FY25 Performance:**
  - 900 patients (2.7% decrease from FY23)

ED Utilization:

- Baseline (-27%): After enrollment in the Multi-Visit Clinic, there was a 27% reduction in ED visits within the first 90 days compared to the 90 days before the first clinic visit. This indicates a positive impact in reducing ED utilization post-enrollment.
- FY23 (-19.4%): The reduction in ED visits slightly decreased to 19.4%, but the clinic still achieved a significant reduction in ED utilization.
- FY24 (-57%): In FY24, the clinic achieved its most notable improvement to date, with a 57% reduction in ED visits among enrolled patients. This sharp decline reflects the growing effectiveness of the Multi-Visit Clinic model, likely driven by improved patient engagement and timely follow-up.
- FY25 (-58.7%): The positive trend continued into FY25, with a 58.7% reduction in ED utilization—surpassing the previous year's success. This sustained improvement reinforces the clinic's role in reducing unnecessary ED visits through comprehensive, patient-centered care and targeted support for high-risk individuals.

Inpatient Utilization:

- Baseline (-28.4%): There was a 28.4% reduction in inpatient admissions within the first 90 days after clinic enrollment compared to the 90 days prior, reflecting a substantial improvement.
- FY23 (-48.4%): The clinic further improved its performance with a 48.4% reduction in inpatient utilization in FY23, showing even greater success.
- FY24 (-43.8%): While there was a slight decline from FY23's peak, the clinic still maintained a strong reduction of 43.8% in inpatient utilization, continuing its positive impact.
- FY25 (-57.8%): In FY25, the clinic achieved a 57.8% reduction in inpatient admissions—one of its strongest outcomes to date. This substantial and sustained decrease highlights the effectiveness of the clinic's multidisciplinary approach, including timely follow-up, individualized care planning, and enhanced coordination across the care continuum.

One-year Outcomes:

- Outcomes from earlier cohorts show reduced emergency department and inpatient utilization, along with a significant increase in outpatient follow-up—demonstrating improved care continuity and patient engagement.
- FY24–25 Bridge to Primary Care: Approximately 200 patients successfully transitioned to Temple Faculty Practice (TFP) providers and completed follow-up visits.
- FY24–25: 119 patients did not engage beyond their initial clinic visit.
- FY24–25: Approximately 580 patients successfully graduated from the program.

Action Plans Implementation Summary:
Diabetes/Prediabetes:

- Implementation of a Community Diabetes Support Group
    - Partnered with Frazier Family Coalition to host monthly free support group to members of Temple Health community.

- Expansion of Services in FY25:
    - Collaborate with inpatient leadership to sustain a strong focus on diabetes care for acute-care patients.
    - Enhance diabetes specific competencies among clinical staff caring for patients in hospital through targeted education and training.
- Growth of Diabetes Prevention Program:
    - Expanded program offerings to faith-based organizations.
    - Established new referral pathways and engaged patients eager for education.
- Community Engagement and Marketing:
    - Maintained a strong presence at local community events to raise awareness and connect with residents.
    - Partnered with the Temple Center for Population Health Mobile Health Van to promote program offerings and extend reach into underserved areas.

Conclusion & Next Steps:
Temple Diabetes Program:

- Enhancing Follow-Up Visits: Increasing the percentage of patients who return to complete the full diabetes education curriculum remains a key priority for the program. Strategies to improve engagement and retention are actively being explored.
- Accessibility of Services: Virtual visits continue to be offered to support patients who face transportation barriers, ensuring equitable access to diabetes education services.

Diabetes Prevention Program:

- Increasing Graduation Rates: A primary goal moving forward is to improve the graduation rate of participants enrolled in the year-long DPP, with efforts focused on sustained engagement and personalized support.

Multi-Visit Clinic:

- Access and coverage:
    - Ensure full-time physician coverage.
    - Maintain catchment for uninsured patients, especially considering upcoming policy changes.
- Expand access to high-risk patients:
    - Increase enrollment of high-utilization patients (≥2 ED visits or recent inpatient stays) by 25% through enhanced outreach and integration with inpatient care teams.
- Accelerate post-discharge follow-up:
    - Achieve >80% completion rate for post-discharge follow-up visits within 7 days for all new referrals by the end of the fiscal year.
- Grow PCP Service Line:

    - Improve PCP conversion rate for MVP clinic graduates by 20% by year-end through standardized handoff workflows and co-management templates.
- Education and engagement:
    - Launch standardized education protocols and materials for the top three chronic conditions (CHF, COPD, diabetes), with a target of 85% utilization during clinic visits.
- Boost multidisciplinary communication:
    - Continue optimizing communication between Community Health Workers (CHWs) and Social Workers (SWs).
    - Transition to a collaborative physical.
- Population health and value-based care:
    - Implement a value-based care pathway (e.g., CHF readmission reduction) aligned with existing ACO/shared savings contracts under Jefferson Health Plans.

Plan Title:
Address Racial, Ethnic and Other Healthcare Disparities

Executive Sponsors:

Abiona Berkeley, MD, JD – *Senior Associate Dean, Health Equity, Lewis Katz School of Medicine at Temple University; Past-President Medical Staff, TUH*
Steven Carson, MHA, BSN, RN – *President & CEO, Temple Center for Population Health*
Cornelius Pitts, PharmD – *Director, COVID -19 Vaccination Project, Center for Urban Bioethics, Lewis Katz School of Medicine*

Health Equity Goals:

1. Strengthen healthcare providers, trainee and other staff training on structural racism, implicit bias, diversity and trauma-informed care to improve culturally appropriate care delivery.
2. Foster a diverse, equitable, and inclusive environment for patients, healthcare providers and other staff from historically marginalized backgrounds.
3. Expand community partnerships to build trust and collaboratively improve healthcare quality, outcomes and value for populations with greatest needs served by the hospital.
4. Collaborate with healthcare providers to examine means of decreasing healthcare disparities within our community.

Objectives:

1. Increase number of faculty, trainees, and staff completing cultural competency training.
2. Increase number of staff from diverse and inclusive backgrounds.
3. Increase community members participating in diversity workforce pathway programs.
4. Examine the relevance and impact of race-based clinical algorithms in healthcare.

Metrics Data Dashboard:

Metric	FY2022	FY2023	FY2024	FY2025
Number of faculty, trainees, and staff completing cultural competency training	1,726	4,308	6,696	541
Number of staff representing diverse and inclusive backgrounds	3,107	3,207	3,757	4,088
Number of TUH community members participating in diversity workforce pathway programs	21	35	83	84

Metric Progress Summary:

- Number of faculty, trainees, and staff completing cultural competency training
    - 541 unique staff members completed online cultural competency training through HealthStream or attended a symposium on cultural competency in FY25.
- Number of staff representing diverse and inclusive backgrounds
    - Temple University Hospital saw a 17% increase in the number of staff representing diverse and inclusive backgrounds from 3,207 in FY23 to 3,757 in FY24. In 2025 the diversity of the workforce grew to 4,088 staff.
- Number of TUH community members participating in diverse workforce pathway programs
    - Four pathway programs in Lewis Katz School of Medicine:

Program	Participants 2023	Participants 2024	Participants 2025
Mini Medical School	9	9	5
Health Career Exploration Day at Katz	3	2	2
Health Career Exploration Day on the road	n/a	41	46
Medical and Basic Science Scholars	16	18	5
PREP Program	7	13	20

- In FY 2024, at the request of members of the Community Advisory Board, TUH collaborated with LKSOM to host a healthcare exploration day at Kenderton Elementary, located two blocks away from the hospital. 41 members of the TUH administration and staff attended the event, which was very well received by all. In 2025, TUH extended its reach to include Bethune Elementary with 46 TUH participants and 1 Board member attending the event.

Program	Students from target zip code	Students from Philadelphia	Target and Philadelphia zip codes
Health Career Exploration Day at Katz	2	8	10
Health Career Exploration Day on the road	133	NA	133
Mini Medical School	5	9	14
Medical and Basic Science Scholars	1	1	2

the community has seen increasing numbers of student participants from the neighborhood engaged in our pathway programs.

- In 2023, Temple University Health System, in partnership with Independence Blue Cross and several health systems in the region, gathered representatives of varied communities of practice within the health system to begin discussions around health equity. The focus was the appropriateness of using race-based clinical algorithms which have been embedded in healthcare nationally and internationally, in some instances for many years. As part of this initiative Temple Health has opposed the use of race in determining:
    - the viability of successful vaginal delivery following cesarean section (VBAC);
    - anemia in parturients;
    - lung function through spirometry;
    - kidney function (eGRF);
    - urinary tract infection in children; and
    - likelihood of kidney stones.

Action Plans Implementation Summary:

1. Educate employees on health disparities and their impact through symposiums, training and continuing education on cultural humility, trauma-informed practices, and anti-bias communication.
    - Temple provides an array of training on cultural competency on the online platform HealthStream. Over 90 courses are available and discuss a variety of topics related to trauma, bias, access and inclusion.
    - Between FY22 and FY25, 13,271 courses were completed by unique members of Temple staff and faculty.
2. Strengthen community engagement, access and inclusive practices within health system's policies, procedures, and quality measures.
    - Temple University Health System remains committed to building its relationship with the members of our community by integrating relevant objectives into its mission and vision. Policies and procedures within the health system are assessed and updated regularly to ensure they promote inclusivity.
3. Partner with local organizations to increase community access to workforce pathway programs.
    - The Lewis Katz School of Medicine offers several pathway programs to amplify community access to Temple's workforce and in medicine.
    - Mini Medical School takes place annually and exposes high school students from the community to careers in the health professions. Since the creation of the TUH Community Advisory Council in 2023, awareness of educational

programming at TUHS has grown in the community. Historically, student participants have come from as far afield as New Jersey and Delaware. This year, ¼ of the student participants in Mini Medical school were from our service area this year and approximately ¾ from Philadelphia.

- The Health Careers Exploration Day is another event that exposes students from the community to learn more about medical school and careers in health. Beyond the growing number of TUHS employees and administrators who have engaged in this program as it expanded into neighboring schools has been the access created for the community members. We have moved from working with 30-50 children to over 150 children annually. Most of those children sit within our service area.
- Medical and Basic Science Scholars is an 8-week program designed to introduce college students to research with a primary focus on students who spent their childhood in the TUH service area. The program had 8 researchers from Temple participate and 3 staff from Fox Chase Cancer Center in FY2025.
- Lastly, the Pre-Matriculation Readiness and Enrichment Program (PREP) is a program supporting participants' smooth transition to medical school and academic success by providing early exposure to the medical curriculum and assisting the development of learning and study-skill strategies. In FY2022, 4 TUH employees volunteered to work with PREP. There has been a steady increase in participation from one fiscal year to the next. This year, 20 TUH employees participated, increasing participation by just over 280% from FY 2022.

4. Collaborate with the community relations team to develop culturally relevant educational materials for patients, community partners, providers, trainees, students, and staff.
5. Engage healthcare professionals in the assessment of the use of race-based algorithms in the practice of medicine and partner with other stakeholders in pursuit of the elimination of healthcare disparities.
6. Develop processes to quantify patient dissatisfaction related to gender, race/ethnicity, sexual orientation, gender identity, disability status, and other cultural competency indicators.
    - The Patient Relations department continues to review grievance cases to identify issues related to gender, race, ethnicity, sexual orientation, and other cultural competency indicators. In FY2023, three cases were identified as discrimination based on age, race and gender. These cases were resolved with inclusivity training mandated for the departments, with the intention of creating a more welcoming and inclusive environment for all patients.
7. Strengthen collection of patient self-reported demographic information "Real Data" on race, ethnicity, gender identity, veteran status, and other areas to improve disparities identification and response.

- "Real Data" fields are collected at the time of new patient registration and updated, as needed, in the electronic medical record.
- Temple has established a consistent and comprehensive approach to data collection across different patient care settings to ensure meeting data requirements for external organizations and to ensure all necessary data fields are maintained. Temple ensures the data collection is inclusive and encompasses various demographic intersections, while also anticipating future demographic reporting criteria set to external bodies.
- In terms of inclusivity, Temple has begun collecting gender related information for employment purposes, transgender identifies and LGBTQ+ affiliations, as well. These questions remain optional for FY2025.

Conclusion & Next Steps:
In terms of health equity goals. The team aims to make continued progress in the new year by focusing on the following:

Objective 1: Increase the number of faculty, trainees, and staff completing cultural competency training.

1. Identify existing training gaps in the current array of courses available to staff.
2. Utilize in-person and online formats to accommodate different learning preferences.
3. Monitor participation and track the number of participants completing the training modules.
4. Regularly evaluate the effectiveness of the training modules.

Objective 2: Increase the number of staff from diverse and inclusive backgrounds.

1. Develop strategies to attract diverse candidates for open positions, including targeted outreach and partnerships with community organizations.
2. Implement inclusive hiring practices to ensure equitable selection of candidates.
3. Continue to offer leadership development opportunities that nurture and promote employees from diverse backgrounds to leadership roles.
4. Increase mentorship and sponsorship opportunities for underrepresented staff.
5. Continue to review and update HR policies to ensure inclusivity and diversity.

Objective 3: Increase community members participating in diverse workforce pathway programs.

1. Conduct targeted outreach to community members, schools and organizations to promote existing pathway programs.
2. Track the number of community members who participate in the pathway programs.
3. Assess the effectiveness of the programs in terms of participants' career advancement and contributions to healthcare.

Objective 4: Examine the relevance and impact of race-based clinical algorithms in healthcare.

1. Continue to identify raced-based clinical algorithms embedded in healthcare.
2. Assess the rationales for the use of race in determining diagnosis and treatment guidelines.
3. Utilize partnership with Independence Blue Cross to assess progress (e.g., billing codes that are tied to race-based algorithms).

By following this action plan, the organization can work towards achieving its health equity goals and objectives, thereby creating a more culturally sensitive and inclusive healthcare environment that serves our patient populations effectively.

Plan Title:
Addressing Social Determinants of Health (SDOH)

Executive Sponsors:
Lakisha R. Sturgis, MPH, BSN, RN – *Director, Community Care Management, Temple Center for Population Health*
Patrick Vulgamore. MPH, ABA - *Director, Addiction Medicine Service Line, Episcopal Campus*

Health Equity Goals:

- Utilize the Power BI platform, a data visualization tool, to inform strategies aimed at addressing non-medical barriers to improving both individual and community health.
- Enhance and expand staff continuing education on trauma-informed approaches for assessing the social determinants of health (SDOH), focusing on the effects of structural racism and implicit bias on healthcare access.
- Engage consumers by offering multiple access methods for care, such as through Healthy Together and Shoprite, ensuring they can choose the option they find most comfortable.

Objectives:

1. Increase number of staff participating in continuing education sessions on trauma-informed approaches to assessing SDOH.
2. Increase number of patients screened for SDOH.
3. Increase number of CHW referrals that result in patients being connected with resources to address identified SDOH.

Metrics Data Dashboard:

Metric	FY22 Baseline	FY23	FY24	FY25
Number of staff attending continuing education sessions on trauma informed approaches to assessing SDOH	0	185	104	13
Number of completed SDOH screenings	110,664	190,563	243,594	254,901
Percent of patients referred to a Community Health Worker (CHW) and connected with resources to address the identified SDOH	87.0%	83.7%	94.7%	94.4%

Metric Progress Summary:

- Number of staff attending continuing education sessions on trauma-informed approaches to assessing SDOH
    - This was a new measure for FY23 where 185 staff attended the educational session and 104 completed the module in FY24. The lack of a coordinated effort to promote continuing education among staff led to 13 members participating in the sessions. We are committed to taking proactive steps to encourage participation and ensure our team is fully engaged in trauma-informed care.
- Number of Completed SDOH screenings
    - Social Determinants of Health refer to the conditions and factors in the social and physical environments in which people are born and live that can impact their overall health and well-being. Screenings are conducted in Ambulatory Care, the Emergency Department, and inpatient units at Temple University Hospital-Main Campus, Episcopal Campus, Jeanes Campus, and Chestnut Hill campus.
    - The number of SDOH screenings completed increased significantly from 110,664 (FY22), 190,563 (FY23) to 243,594 (FY24), 254,901(FY25) >150% increase from baseline.
- Percent of patients referred to a Community Health Worker connected with resources to address the identified social determinants of health.
    - The CHW connection rate fluctuated from 87.0% (FY22) to 83% (FY23) increased to 94.7%(FY24) and remained the same at 94.4 (FY25)

Action Plans Implementation Summary:

1. Participate in interdisciplinary workgroups to review SDOH data and develop strategies for data collection and response improvement.
    - The SDOH Steering Committee includes leadership as well as medical, nursing, and social work representatives from across the health system. Screening data is presented to this group quarterly, followed by discussion of interventions and response improvement.
    - The steering committee is also focused on opportunities for performance improvement at the inpatient unit level.

2. SDOH screening data are reviewed in ambulatory quality meetings for Chestnut Hill Physicians (CHP), Temple Faculty Practice Plan and Temple Physicians Inc. Promoting staff continuing education on assessing patients for SDOH using a trauma-informed approach.
    - A custom HealthStream module created and launched in January 2023 that reviews SDOH screening questions and trauma-informed communication skills for conducting the screening.

- In Spring 2023, all TFP and TPI clinic staff who conduct SDOH screenings were required to complete the module. CHP providers were added in 2024.
- The module is available to all employees in HealthStream and can be assigned by managers.
- In FY24, 104 staff members completed the SDOH HealthStream module. FY25, although Social Determinants of Health (SDOH) remain a key organizational priority, the lack of targeted promotion for the available module has limited staff awareness and engagement.

3. Consult trusted community advisors on how nurse navigation and community health worker services can be designed and implemented to maximize community participation and benefit.
    - A Community Advisory Council was launched in December 2022 to advise Temple University Hospital Inc. on community priorities and feedback. After the initial launch, the council had two meetings in FY23, five meetings in FY24 and 4 in FY25.
    - Temple's comprehensive SDOH program was presented to the council, including screening processes and results. The Community Health Worker program and other community outreach initiatives to address SDOH were reviewed in detail with the council, which provided valuable feedback.
    - Patient feedback was also recently obtained in the TFP Primary Care Clinics through their Patient and Family Advisory Councils.

4. Partner with other trusted local health systems, managed care organizations, social service providers and other organizations that provide housing, food, transportation, internet access and other SDOH resources. Engage in shared learning to advance health equity.
        - Temple is deeply engaged with a variety of community-based organizations, working tirelessly to bridge the gap between patients and vital resources that address social determinants of health (SDOH). For instance: Temple partners with Uber Health provide rides to appointments for patients who lack access to reliable transportation.
        - Temple partners with Philadelphia Legal Assistance to embed a legal aid program in high-risk primary care practices.
        - Temple partners with a local internet provider to provide low-cost internet as part of our Digital Equity Program that also includes computer training.
    - With more than 40% of our community relying on SNAP benefits, access to nutritious food remains a significant challenge. To address this need, Temple launched a food program that removes barriers by offering no-cost access to healthy foods through

both an on-site pantry at Episcopal Hospital and a delivery service operating from the same location.
    - In partnership with Sharing Excess, the Philadelphia Share Food Pantry Program, and Food Connect, the pantry served nearly 28,000 individuals last year, with each pantry bag providing enough food for three days. In addition, the delivery program completed over 8,000 deliveries, each with enough produce and pantry items to feed four people for two days.
    - The food programs also collaborate with the Diabetes Prevention Program to incorporate Diabetes Education with access to nutritious food and recipes using the food that is available that week.
    - In fiscal year 2025, Temple partnered with Philabundance to deliver produce and nutritional education to Keystone First patients managing specific chronic conditions. Over 50 Temple Health patients were referred to the program.
- We partnered with GSK to launch targeted educational programs to address vaccine hesitancy. This partnership focuses on building trust through culturally responsive materials, community outreach, and provider training, with the goal of improving vaccine confidence and increasing vaccination rates among underserved populations. FY25, >900 patients were engaged.
- Temple partnered with Jefferson Health Plans to address SDOH and has received funding for SDOH programming including a new Community Health Worker position in the Emergency Department at Temple Main, as well as urgent food deliveries and care coordination.
- With more than 40% of our population living below the federal poverty level, housing insecurity remains one of the greatest barriers to achieving optimal health. In response, Temple established a multidisciplinary, community-based team with direct access to both short- and long-term housing programs, helping individuals stabilize, pursue independence, and engage in preventative healthcare.
- Through partnerships with the City of Philadelphia, community-based organizations, and other healthcare systems, the program is setting a new standard for comprehensive care in vulnerable communities. In the past year alone, the team enrolled 87 participants, recorded more than 3,000 interactions, and successfully placed 14 individuals into long-term housing.
- Together, Temple and Jefferson Health Systems lead the Frazier Family Coalition (FFC). The goal of the FFC is to reduce the instances of stroke in North Philadelphia. To address food insecurity and reduce the risk of chronic conditions, the FFC delivers fresh produce with recipes on a weekly basis to community members in the FFC target zip codes.

5. Collaborate with the community relations team to develop educational materials to increase staff and community partners' participation in SDOH training and other efforts.

- Temple participates in a city-wide collaborative effort led by the Philadelphia Department of Public Health and FindHelp to promote city-wide education and training around SDOH, including education of community partners.

6. Promote the use of the Temple Community Health Connect resource directory (FindHelp) among internal and external stakeholders.
    - Temple Community Health Connect (also known as FindHelp) is actively promoted across Temple through the strategic placement of posters. The site's QR code appears on After Visit Summaries in outpatient clinics when patients screen positive for SDOH. In the Emergency Department, flyers including the same QR code are given to patients.
    - Temple Community Health Connect is also promoted at community events including health screenings and programs offered by Healthy Together, our mobile health van.
    - Temple Health signed a contract with Health Share Exchange to add PA Navigate to its resources. This program will add SDOH data that may have been collected at other organizations related to a deficit in SDOH. This new program is slated to go live in 2025 and will help improve the coordination of community-based resources.
    - For FY25, Temple Community Connect will be added to key care management staff workflows in the EPIC EMR to facilitate the referral process.

7. Lead and participate in culturally appropriate community events that connect community members with needed resources.
    - In FY23, Temple's Healthy Together mobile health van participated in 29 events, engaging with 2,737 community members at various retail establishments, community and faith-based locations in the North Philadelphia corridor and surrounding areas.
    - In FY24, Temple Health launched the "Healthy Together" site at Brown's Shoprite of Fox Street. Our Mobile Health Van and site at Brown's Shoprite in Fox Street allow us to reach out and address undiagnosed chronic conditions like hypertension and diabetes. We also provide essential resources for social drivers of health such as transportation, food, and housing. Through both programs, we engaged with over 10,000 community members.
    - The Healthy Together initiative, featuring our Mobile Health Van and the site at Brown's Shoprite on Fox Street, continues to exceed expectations. For FY25, we engaged 3,564 community members through the Mobile Health Van and 9,923 at the Shoprite supermarket, a marking increase of >25% compared to FY24. These initiatives enable us to identify and address undiagnosed chronic conditions such as hypertension and diabetes. Additionally, we provide essential resources related to social determinants of health, including transportation, food, and

housing. Importantly, increasing access to health care by connecting patients to primary care providers.

Conclusion:

Temple has made consistent progress in addressing Social Determinants of Health (SDOH), marked by steady increases in screening rates across care settings. Quality improvement initiatives have significantly raised SDOH screening rates in both Primary Care and the TUH-Main Campus Emergency Department. The introduction of Power BI in FY25 provided real-time dashboards that track and trend SDOH screenings, positivity results, interventions provided, and documentation rates. As we will continue to evaluate the need for additional training strategies. With the new partnership and funding from Highmark, new Full-Time Equivalents (FTEs) were added to the team during FY24: A Community Health Worker (CHW) was placed in the Episcopal Hospital Emergency Department to address SDOH. In February 2024, a Social Worker was assigned to the Multi-Visit Patient Clinic to address the complex needs of patients presenting with behavioral health issues and substance use disorders. In FY25, two additional staff were assigned to the Housing Initiative and two to the GSK vaccination initiative. The CHW team is dedicated to connecting patients with resources related to SDOH across multiple settings. To further improve our SDOH response, the documentation and tracking processes for CHWs in EPIC have been redesigned to 1) increase visibility for referring clinicians and 2) allow for weekly tracking of referrals, interventions, and response times. We anticipate that this enhanced data will facilitate ongoing optimization of our SDOH response and help identify any additional resources that may be needed. In fiscal years 24 and 25, the CHW program focused on closed-loop communication with a goal of achieving a 3-business day response rate.

Next Steps:

- For FY26, our focus will shift towards measuring impact, with an increase in face-to-face assessments and support efforts in their respective primary care offices.
- Expand services to increase access to resources that address SDOH through our Healthy Together initiatives.
- Pursue sustainable funding models through reimbursement mechanisms, grants, and alignment with value-based care initiatives.
- Expand capacity by increasing pantry hours and scaling delivery routes to reach more households.
- Strengthen partnerships with regional food distributors and local farms to increase fresh food availability.
- Scale enrollment was beyond the initial 87 participants by expanding referral pipelines from healthcare and community partners.
- Track and report outcomes on health utilization (ED visits, hospital admissions) to strengthen the case for ongoing investment.
- Build financial sustainability by integrating housing navigation into value-based care models and securing reimbursement streams.

Executive Sponsors:
Abhijit Pathak, MD; Jill Volgraf, RN

Health Equity Goals:

1. Establish a behavioral health program for violently injured patients and families entering the hospital to support trauma recovery.
2. Strengthen underserved populations' access to crime victim services to address social determinants of health.
3. Increase job readiness among violently injured patients living in communities with chronic unemployment rates as a means to break the cycle of violence.

Objectives:

1. Improve Temple Victim Advocacy Program's collaboration with victim service agencies and increase the number of patients referred to these programs.
2. Increase the number of violently injured patients referred to behavioral health counseling pre- and post-discharge.
3. Improve violence survivors' access to job training and employment opportunities.

Metrics Data Dashboard:

Data Element	Baseline	FY23	FY24	FY25
Patients receiving case management services	0	557	770	326
Patients referred to crime victim service agencies	226	411	483	237
Patients referred to outside behavioral health services	0	155	184	65
Patients engaged through workforce development programs	0	348	0	123
Number of job readiness hosted	0	9	0	0

Metric Progress Summary:

- Increased the number of patients receiving relocation support by 50%.
- Increased the number of patients receiving emergency food assistance by 66%.
- Experienced a 20% reduction in shooting victims compared to the previous year.

Action Plans Implementation Summary:

- Completed an independent outcome evaluation with the Genoa Group to assess program outcomes, strengthen operations, and expand impact.

- Secured funding to maintain the Trauma Victim Advocacy Program's advocates through 2027.
- Continued our partnership with Temple University's School of Social Work which placed a clinical social work intern on our team to provide mental health support at bedside.
- Maintained funding to provide emergency relocation services to survivors of gun violence.
- Maintained funding to provide emergency food and clothing to program participants.
- Redefined the Workforce Development Specialist role as a Violence Recovery Coordinator to provide more comprehensive support for victims.
- Hosted the Temple University Hospital's second Violence Survivor's Day to celebrate the resilience of program participants.
- Began implementation of the QuesGen System Inc. case management platform to improve data collection, evaluation, and reporting.
- Created a program manual to standardize procedures, improve consistency, and strengthen the quality of support provided to victims.

Conclusion & Next Steps:
During this reporting period, the program made important progress, including the implementation of a new case management system to strengthen service delivery, the acquisition of new funding sources as prior grants expired, and membership in the Hospital Alliance for Violence Intervention (HAVI), which provides access to valuable training and technical assistance. At the same time, the program faced challenges related to staff reductions in workforce development and mental health support, which limited our ability to fully achieve some objectives. To address these challenges, we are restructuring key positions and pursuing additional funding to restore and expand staffing capacity, ensuring the program's continued growth, consistency, and impact in the community.